RESPONSIVENESS SUMMARY
Health Benefits Eligibility and Enrollment Proposed Rules (GCR 17-043 through 17-049)
October 20, 2017

General Comments

Comment: The Agency of Human Services (AHS) should harmonize procedures across all of the Vermont health benefits programs, to the extent this is prudent and possible. This effort should include notice requirements, time frames, benefit appeals, and eligibility appeals. We understand that there are different minimum requirements for different situations under federal law, and standard procedures may not be appropriate for every type of notice, grievance, or appeal. However, AHS could seek additional waiver authority to standardize these rules if it believed that to be necessary. A simplified system of rules would reduce consumer confusion and be easier to administer.

We support AHS's Health Care Administrative Rules (HCAR) project. This will bring Vermont's health program rules into a unified format, update outdated rules, and ensure that all of Vermont's health benefits programs have rules. We suggest that a broad systemic review of procedures be undertaken as part of the HCAR project. For example, when incorporating DVHA appeal rules into HCAR, AHS should consider whether the procedures can be harmonized with those under HBEE. Likewise, when HBEE rules are updated, AHS should consider the extent to which procedures differ from those in HCAR and other program rules, and harmonize as many of them as possible.

Response: The agency will continue to seek to harmonize notice and appeal requirements and processes to the extent it is possible and beneficial to applicants and enrollees to do so. The agency has fully aligned eligibility notice and appeal processes for Medicaid and QHP-related benefits in HBEE rule and operations except that there is a different time frame for resolving expedited appeals that involve long term care Medicaid and MABD community Medicaid, due to their relative complexity compared to MCA community Medicaid and QHP-related health benefits. It is more difficult for the agency to align notice and appeal processes between Medicaid eligibility and Medicaid services due to the significant differences in federal legal requirements for eligibility and service notices and appeals; however, the agency will do so to the extent prudent and possible.

Comments by Rule Sections

PART ONE

4.02(b) Right to nondiscrimination and equal treatment

Comment: Religion was removed from this section as a basis upon which AHS does not unlawfully discriminate. We assume this was a drafting error and recommend that the word "religion" be restored.

Response: The agency is revising the section to include the word "religion."

5.03 Navigator Program

Comment: With the expansion of the listed areas of expertise for navigators, we note the importance of training to ensure that all navigators fully understand and are able to meet the listed standards. We request that AHS collaborate with the HCA when it is developing and updating its standards for navigators. We also support a fully funded and robust Navigator program which will be able to provide in person help to Vermonters who need it.

Response: The agency agrees with the importance of the navigator program including adequate training for navigators. The agency appreciates the HCA's offer to collaborate in training development and will urge the program staff to continue to work closely with stakeholders. A discussion of the budget for the navigator program is outside the scope of this rulemaking.

Comment: I am requesting that you revisit the Navigator Program. In particular pages 34-48. I believe that this rule is out dated and needs to reflect current day needs. I look forward to seeing some new language once this rule is reviewed.

Response: The agency has reviewed the in-person assistance sections, as suggested by the commenter, and made revisions at 5.04(b) and 5.05(b) to align with current program operations.

PART TWO

8.05(d) Individual with disabilities who is working (Medicaid for working people with disabilities (MWPD))

Comment: I have been waiting for this opportunity since 2001 when I first became eligible for SSDI. I am ecstatic to submit public comments in support of the above referenced program updates.

I fully intend to reapply for MWPD after the changes are implemented. I want and need to continue working. I feel like the State of Vermont has been lackadaisical in developing, seeking, and implementing changes to the MWPD program that not only promote wellness for the disabled individual but support his/her effort to remain or become a tax payer. This is not a hand-out. It is a common-sense program change that is not only good for me but the State of VT too.

Response: The agency appreciates the commenter's support of the enhancements being proposed to the income and resource exclusions for the MWPD program and is glad to hear from someone who will directly benefit from these enhancements.

Comment: I would like to take the opportunity, during the public comment period, to remark on the rule amendments to the Medicaid for Working Persons with Disabilities (MWPD) program. I thank you and the Agency of Human Services (AHS) in advance for your consideration.

First of all, the 3 rule changes appear to be straightforward and in accordance with the MWPD provisions within Act 51 of the 2015 Vermont State legislative session and with AHS final policy as posted in the Global Commitment Register (GCR), effective 8/1/2016. As the lead advocate for these work incentive enhancements, I have no issues whatever with the language denoting the changes.

As for the one change legislated but disallowed by the Centers for Medicare and Medicaid Services (CMS) – the "reverse" spousal income disregard (i.e. disregarding the income of the MWPD beneficiary spouse for purposes of determining eligibility of the non-MWPD spouse for a Medicaid program), the denial appears to be solidly and soundly based. Because, as per Federal regulation, no disregards are allowed for MAGI Medicaid, nothing can be done at a state level to reverse that decision as it affects MAGI Medicaid. However, it is my understanding that, in the future, it may be possible to rework the relevant Medicaid State Plan Amendment (SPA) to more precisely define the income disregard parameters for non-MAGI Medicaid (e.g. Aged, Blind and Disabled Medicaid) prior to re-submission to CMS for approval. The more encompassing rationale for denial – the comparability rule – may be satisfied by such a refinement which would also preclude inadvertently extending the scope of the disregard well beyond the intent of Act 51. Of course, any refined rule amendment would apply to a smaller population than the original rule.

At this time, there exists some uncertainty regarding the issue of whether those former MWPD beneficiaries or potential beneficiaries now over 65 years of age can validly apply or re-apply for the MWPD program. A percentage of this population may have lost eligibility or been denied eligibility under the current rules but would not have under the proposed rules. Fairness seems to dictate that this population be allowed to apply/re-apply. Further, clarification is needed to generally explain whether re-application is allowed for this population after a break in employment and thus loss of eligibility for MWPD. Of course, Vermont's MWPD program is authorized by the Federal Balanced Budget Act (BBA) of 1997 which does not contain a termination age for Medicaid Buy-in (MBI) programs.

I applaud the efforts of AHS toward a thorough clarification of the issues stated above and look forward to a well-thought out response.

I am also pleased by proposed pro-active efforts by AHS to reach out to a targeted population of those, generally, who might have lost eligibility or been denied eligibility under the current rules but who would not have under the proposed new rules. Although it might not be technically feasible/possible to identify specific individuals, my understanding is that AHS will make every reasonable effort to publicize the new rules, including utilizing Department of Vocational Rehabilitation (DVR) benefit counselors, as well as the collaboration of such entities as the Statewide Independent Living Council (SILC) and Vermont Center for Independent Living (VCIL). In addition, pertinent information will be posted on appropriate State Websites.

In summary, much thanks to the AHS "team" which has been diligently working to bring the legislated changes to fruition. I am hoping and trusting the remainder of the prescribed 6-month rule-making process proceeds accordingly in anticipation of the scheduled implementation date of January 1st, 2018.

Response: The agency appreciates the commenter's support of the enhancements being proposed to the income and resource exclusions for the MWPD program and for identifying other issues for consideration connected to the program. While those other issues are outside the scope of this rulemaking process, they are being reviewed by the agency. The agency is grateful for the collaborative

relationship it has with its community partners with respect to the MWPD program and looks forward to continued open dialogue on the program, both generally and with respect to these additional issues.

PART FOUR

24.04(e)(1)(ii) Allocation to other family members

Comment: We support the proposed clarification that income allocation to a family member is only available when no community spouse is living in the home.

We further support the addition of a reference to the community spouse resource allocation (CSRA) minimum. This clarifies the applicable standard. However, we do not believe the rule should refer readers to the Vermont Medicaid Procedures Manual. Rather, the federal CSRA regulations should be referenced directly. (42 CFR §§ 435.725, 435.735, and 435.832.) This could be done in a footnote rather than in the text, for clarity.

Response: The agency appreciates the commenter's support of the clarifications being proposed regarding the allowable deduction from an individual's income for the maintenance needs of family members when calculating the individual's patient share obligation. The purpose of these proposed clarifications is not, however, to limit the allocation so it is only available when there is no community spouse, and the agency wants to take this opportunity to be clear on the changes being proposed.

The purpose of these proposed revisions is to clarify the resource limit for family members when determining their eligibility for an allocation. The current rule sets a limit of $12,000 on the countable resources allowed by a family member. The proposed rule will (1) raise that limit to the then-current community spouse resource allocation (CSRA) minimum when there is no community spouse living in the home, and (2) eliminate the resource limit altogether when there is.

The agency also appreciates the commenter's support of adding a reference in this rule provision to the CSRA minimum, but disagrees that a reference to the federal regulations is preferable to a reference to the Vermont Medicaid Procedures Manual. The reason for the reference is to provide a link to a source that states the actual amount of the current CSRA minimum so the resource limit, when it applies, can be readily known. That amount is stated, and updated, in the Vermont Medicaid Procedures Manual. The references to the federal regulations suggested by the commenter would not accomplish this purpose as none of those regulations state the amount of the CSRA minimum. Accordingly, no change will be made to this rule provision.

PART FIVE

29.08(e)(1)(F)(i) Excluded trusts; in general

Comment: We support the proposed change to this section. The change expands the special needs trust (SNT) resource exclusion to include a SNT created by a disabled individual after 12/16/16.

Response: The agency appreciates the commenter's support of this proposed change.

29.08(i)(3)(ii)(E) Independent living contracts; exclusion

Comment: This provision caps payments for care and services under an Independent Living Contract (ILC) at Choices for Care (CFC) payment rates. AHS should ensure that these caps allow caregivers to make a livable wage.

Response: No revisions are being proposed to this provision of the rule. Comments with respect to existing policy are not within the scope of this rulemaking effort. However, the agency appreciates the commenter's concern, and will take it into consideration.

29.10(e) Determining countable resources for individuals requesting Medicaid coverage of long term care services and supports under MABD who have spouses

Comment: We do not believe the rule should refer readers to the Vermont Medicaid Procedures Manual for the community spouse resource allocation (CSRA) maximum. Rather, the federal CSRA regulations should be referenced directly. (42 CFR §§ 435.725, 435.735, and 435.832.) This could be done in a footnote rather than in the text, for clarity.

Response: The agency disagrees with the commenter that a reference to the federal regulations is preferable to a reference to the Vermont Medicaid Procedures Manual. The reason the agency is proposing this added text is to provide a link to a source that states the actual amount of the current CSRA maximum. That amount is stated, and updated, in the Medicaid Procedures Manual. The references to the federal regulations suggested by the commenter would not accomplish this purpose as none of those regulations state the amount of the CSRA maximum. Accordingly, no change will be made to this rule provision.

29.14 (g)(1)(i) & (h)(1)(i) Long-term care individuals

Comment: We support the proposed changes to these sections. The updated language recognizes that the provisions apply to a broader range of family members than just dependent children.

Response: The agency appreciates the commenter's support of this proposed change.

PART SEVEN

60.00 Computing the premium-assistance amount

Comment: In general, this section of the rules should better include and explain the availability of Vermont Premium Assistance (VPA). It is only mentioned briefly in § 60.07. A sentence or two should be added to explain VPA generally. New § 61.01(b) could be created for this purpose, or the language could be added to § 61.01.

Also, we note that Vermont Health Connect uses the term Vermont Premium Assistance in its consumer communications. That term should be used in the HBEE rules as well, rather than "Vermont Premium Reduction" (in § 60.07 currently). The statute refers to "premium assistance." 33 V.S.A. § 1812(a)(1).

To footnote 68, a citation should be added to the Vermont financial assistance authority, 33 V.S.A. § 1812.

Response: The agency agrees that clarification regarding the VPA program would be helpful and is adding a description of VPA at 60.01, as well as a citation to its statutory basis in 33 VSA 1812. The agency appreciates the comment regarding the name of the program and will consider that change in future rulemaking.

60.01 In general

Comment: The second sentence should be revised to read, "A tax filer's federal premium assistance credit amount for a benefit year is the sum of the premium-assistance amounts determined under § 60.04 for all coverage months for individuals in the tax filer's household." § 60.04 only includes federal assistance.

Response: The agency is revising this section as suggested by the commenter.

60.03(d) Appeals of coverage eligibility

Comment: We support the addition of this provision, which gives consumers 120 days to pay premiums if the consumer enrolls in retroactive coverage pursuant to an appeal decision. Most consumers do not have the funds available to pay multiple months of premiums immediately.

Response: The agency appreciates the commenter's support of this proposed change. Please note that this rule does not change the QHP premium due date as described in section 64.04. This rule clarifies that, for purposes of claiming the premium tax credit, a customer will not be penalized for paying premiums after the tax filing deadline if retroactive enrollment and APTC for that tax year is a result of an eligibility appeal decision.

60.04 Premium assistance amount

Comment: The text in § 60.04 should be clarified to explain that it refers to federal premium subsidies only. Alternately, the title of this section could be changed to "Federal premium assistance amount."

Response: The agency is changing the title of the section as suggested by the commenter.

60.07 Applicable percentage

Comment: The examples in § 60.07(d) should incorporate VPA. Alternately, the introductory text should clarify that the examples only include federal assistance calculations.

Response: The agency is making a revision to clarify that the examples in this section relate to the federal applicable percentage.

61.00(c) Normal maximum time for determining eligibility

Comment: This rule should be clarified to state when an application will be considered "based on a person's disability." (§ 61.00(c)(1)). Which programs does AHS consider to fall under that provision? Recently a dispute arose regarding a Vermont consumer's application for the Medicare Savings Programs.

We believe that the plain language of the rule should control, as it is directly from the federal regulation cited. The 90-day time frame should not apply to an applicant 65 years or older applying for Medicare Savings Programs, the VPharm pharmacy program, or Medicaid for Aged, Blind and Disabled. Once a consumer turns 65, eligibility for those programs are based on age, and should be processed in the normal 30-day time frame absent extenuating circumstances.

Response: No revisions are being proposed to this provision of the rule. Comments with respect to existing policy are not within the scope of this rulemaking effort. However, because of the possibility of there being confusion about the meaning of this rule provision, the agency wants to take this opportunity to clarify its meaning.

The 90-day timeliness standard for making a decision on an application that is "based on a person's disability" is not driven by the Medicaid program for which the individual is applying; it is driven by the Medicaid eligibility category under which the individual is applying.

If an individual is applying for Medicaid as a disabled individual (that is, they are applying under the "disability" category) and there has not yet been a determination of their disability by the Social Security Administration, the additional time allowed in this rule provision for making a decision (90 days instead of 30) is to give the State sufficient time to make that disability determination. As the text of this rule provision aligns with the text of the corresponding federal regulation, no revisions will be made to it. For a discussion by the Centers for Medicare & Medicaid Services (CMS) of the federal regulation, see 54 Federal Register 50755, at 50758, December 11, 1989.

64.01(h) Conditions of eligibility and enrollment

Comment: This section, as it pertains to qualified health plans states: "timely payment of a premium is required as a condition of initial and ongoing enrollment." BCBSVT is concerned that this language does not clearly specify that in order for initial coverage to be effectuated, the initial premium payment must be received by Vermont Health Connect (VHC). As you know, VHC has had some challenges collecting premiums for coverage provided. This lack of supporting premium for coverage drives up overall costs for those VHC enrollees who are paying their premiums. Although this section provides that as a condition of initial enrollment, premium must be paid, we suggest adding language like the following to make it more explicit that an initial timely payment must be made before coverage will be effectuated: "Coverage shall not be effectuated until the initial payment of all premium due has been received by VHC. If the initial payment is not received timely, the coverage effective date may be changed or coverage may not be effectuated, depending on the enrollee's enrollment rights."

Response: The agency is adding a new subsection (f) in 71.01 (requirements for QHP enrollment) to clarify that initial payment is required for effectuation, as suggested by the commenter.

67.00 General notice standards

Comment: We support the wording changes made to this section; the new proposed language is clearer.

Response: The agency appreciates the commenter's support of this proposed change.

68.01(b)(1)(iii) Notice of Decision and Appeal Rights

Comment: We object to limiting this rule to decisions related to Medicaid eligibility. AHS should provide specific reasons supporting a decision to deny, reduce, suspend, or increase liability for beneficiaries enrolled in any health care program, including federal and state premium assistance. For consumers to fully understand AHS's decision and exercise their appeals rights, they must know the specific reasons for the decision.

Response: The agency is changing this proposed revision, as suggested by the commenter, to remove the limitation to Medicaid.

68.02(a) Advance Notice of Adverse Action decision

Comment: We object to limiting this rule to Medicaid enrollees only. Consumers who receive federal or state premium assistance should also get advance notice of an adverse action impacting their eligibility. Advance notice is particularly important for this group because the adverse action may trigger a Special Enrollment Period (SEP), and the consumer needs to be aware of when the 60 day SEP time period starts. Consumers whose APTC, VPA, or CSR is being reduced due to a redetermination should receive advance notice of the change.

QHP consumers already receive advance notice of one type of averse action: closure for nonpayment. We are not proposing that AHS send a separate adverse action notice for the closure of QHPs; those consumers receive grace period notices under section 64.06.

If the limitation is maintained in the final proposed rule, please clarify what is meant by "Medicaid" in this section. Does it include CHIP, VPharm, and Medicare Savings Programs?

Response: The agency is adding language at 68.01(a) to clarify that notices of adverse decisions are provided in advance across programs.

71.03(d)(14) Special Enrollment Periods; pregnancy

Comment: The special enrollment period (SEP) for pregnancy should be available to current VHC enrollees as well as new enrollees. Access to prenatal care improves the health outcomes for both mother and baby, and reduces overall costs in the healthcare system. Many pregnancies are unplanned, and often a woman would have enrolled in more appropriate health insurance had she known she would become pregnant. Currently, an enrollee who experiences complications in her pregnancy may not be able to afford appropriate care, particularly if she has a catastrophic plan.

The statute on which this SEP is based does not explicitly limit the SEP to new enrollees.

> *"A registered carrier shall allow for the enrollment of a pregnant individual, and of any*

individual who is eligible for coverage under the terms of the health benefit plan because of a relationship to the pregnant individual, at any time after the commencement of the pregnancy. Coverage shall be effective as of the first of the month following the individual's selection of a health benefit plan." 33 V.S.A. § 1811(l).

We recognize that AHS has discretion to interpret the statute where the text and legislative intent are not clear. However, because of the strong public policy considerations, we believe the statute should be interpreted broadly to apply to both current and new enrollees.

Response: The agency appreciates this comment but understands this statutory special enrollment period to apply only to new applicants. The agency is not revising the proposed language at this time.

73.05(b)(1)(iii) Data matching; tax filing

Comment: We support the addition of this section. It is appropriate and important to accept re-attestation of tax filing because nonfilter data received from the Internal Revenue Service (IRS) via the federal data hub can be out of date or inaccurate. According to the Treasury Inspector General for Tax Administration (TIGTA), for the 2016 enrollment period "the IRS erroneously notified the Exchanges that a required Tax Year 2014 return was not filed for 87,271 (25 percent) of the 342,450 individuals for whom the IRS sent notifications." Affordable Care Act: Verification of Premium Tax Credit Claims During the 2016 Filing Season, TIGTA Reference Number: 2017-43-022, p. 22 (Mar. 2, 2017). TIGTA also raised concerns about IRS delays in processing and uploading nonfilter data. Id. at 24.

Response: The agency appreciates the commenter's support of this proposed change.

77.00(e) Allocation of APTC and the Vermont Premium Reduction among policies

Comment: We support the revisions to this section. The allocation rule that AHS proposes is appropriate and simple to administer.

On an operational note, we appreciate that VHC is able to process enrollments with APTC and VPA for two tax families who wish to be covered by the same plan. This is necessary to allow adult children to remain on a parent's VHC plan until age 26. Most other exchanges have not developed that capability despite provision for it in the federal regulations.

Response: The agency appreciates the commenter's support of this proposed change.

PART EIGHT

80.07(d)(2) Expedited Administrative Appeals

Comment: Proposed § 80.07 addresses expedited administrative appeals. We support the expansion of this section to include all types of Medicaid. This is an important step towards harmonizing procedures across health programs.

Proposed § 80.07(d)(2)(i) establishes timelines within which hearing and notice of decision must occur for resolving expedited administrative appeals. The proposed rule establishes different timeframes for appeals involving MABD and Medicaid coverage of long-term care services and supports (under both MCA and MABD), versus appeals not involving Medicaid coverage of long-term care services and supports. Specifically, AHS proposes 7 business days from the date of the request for appeals involving QHPs or MCA not involving coverage of long-term care services and supports. It proposes a resolution "as expeditiously as possible" for appeals involving MABD or Medicaid coverage of long-term care services and supports. We question the rationale for affording different levels of protection for different beneficiaries and recommend that expedited appeals for all beneficiaries be resolved within the 7 business day timeframe.

Proposed § 80.07(d)(2)(ii) purports to set an outside time limit of 21 days within which AHS must issue a written decision in expedited appeals. Proposed § 80.07(d)(2)(ii) makes reference to "the timeframe in [80.07(d)(2)](i)." However, as noted above, for appeals involving MABD or Medicaid coverage of long-term care services and supports, no timeframe is established in 80.07(d)(2)(i). Rather, expedited appeals involving MABD or Medicaid coverage of long-term care services and supports must only be resolved "as expeditiously as possible." Again, we recommend that expedited appeals for all beneficiaries be resolved within the 7 business day timeframe. As suggested in proposed § 80.07(d)(2)(ii), there may be an exception to the 7 day timeframe for "unusual circumstances."

Response: The agency is making a technical change in the third sentence in HBEE 80.07(d)(2)(i) to make "timeframe" plural to align with the two appeal timeliness standards that are referenced in the same rule provision.

42 CFR 431.244(f)(3)(i), effective January 20, 2017, newly requires that the agency provide an expedited timeframe for Medicaid eligibility appeals when criteria is met and that expedited appeals be resolved "as expeditiously as possible." Instead of aligning the timeframes for all Medicaid eligibility appeals to the "as expeditiously as possible" timeframe, the agency thinks it is important to keep the current timeframe for MCA community Medicaid appeals to seven working days. It is not administratively feasible for the agency to process expedited appeals for MABD and long-term care Medicaid (both MCA and MABD) within seven working days due, in part, to the relative complexity of these appeals.

The rule provision at 80.07(d)(2)(ii) requires that all Medicaid appeals (MCA and MABD community and long-term care Medicaid) be processed within a maximum of 21 days if there are unusual circumstances as defined by the rule.